Exhibit A

Original Application

THE INSURED	IOANNIS TRIANTAFILLOU	REGISTER DATE	NOV 17, 1988
POLICY OWNER	IOANNIS TRIANTAFILLOU	DATE OF ISSUE	DEC 7, 1988
FACE AMOUNT	$500,000	ISSUE AGE,SEX	33, MALE
POLICY NUMBER	[redacted]6 693	BENEFICIARY	SEE PAGE 4

BENEFITS AND PREMIUMS

BENEFITS	MONTHLY PREMIUM	PREMIUM PERIOD
LIFE INSURANCE	$502.00	FOR LIFE
DISABILITY PREMIUM WAIVER	35.00	TO AGE 65
PAID-UP ADDITIONS	8.34	FOR LIFE

THE FIRST PREMIUM IS $545.34 AND IS DUE ON OR BEFORE DELIVERY OF THE POLICY. SUBSEQUENT PREMIUMS ARE DUE ON DEC 17, 1988 AND MONTHLY THEREAFTER DURING THE PREMIUM PERIOD IN ACCORDANCE WITH THE ABOVE PREMIUM TABLE.

TABLE OF VALUES
(SEE PAGES 5 AND 6 FOR DETAILS)

END OF POLICY YEAR	CASH SURRENDER OR LOAN VALUE	REDUCED PAID-UP INSURANCE	EXTENDED TERM INS. YRS.	EXTENDED TERM INS. DAYS	END OF POLICY YEAR	CASH SURRENDER OR LOAN VALUE	REDUCED PAID-UP INSURANCE	EXTENDED TERM INS YRS	EXTENDED TERM INS DAYS
1	$ 0	$ 0	0	90	13	$ 77,500	$216,500	18	72
2	0	0	0	90	14	85,000	230,500	18	149
3	11,500	47,500	7	166	15	92,500	243,000	18	188
4	17,500	69,000	10	25	16	100,000	255,000	18	196
5	23,500	89,000	12	16	17	108,000	267,500	18	203
6	29,500	107,000	13	196	18	116,000	278,500	18	184
7	36,000	125,000	14	293	19	124,000	289,500	18	145
8	43,000	143,500	15	314	20	132,500	300,500	18	109
9	49,500	158,500	16	185	AGE 60	193,000	362,000	16	194
10	56,500	173,500	17	27	AGE 62	211,500	377,000	15	318
11	63,500	189,000	17	214	AGE 65	239,000	396,500	14	287
12	70,500	203,000	17	350	AGE 70	284,500	423,500	12	327

THESE VALUES FOR THE POLICY ASSUME THAT ALL PREMIUMS ARE PAID. THEY DO NOT REFLECT DIVIDEND CREDITS, PAID-UP ADDITIONS OR LOANS.

THIS PAGE TO BE ATTACHED TO AND MADE A PART OF POLICY NUMBER [redacted]6 693.

POLICY INFORMATION EFFECTIVE NOV 17, 1988
REFLECTS APPLICATION DATED NOV 8, 1988

---------- BENEFITS AND PREMIUMS ----------

BENEFITS	MONTHLY PREMIUM	PREMIUM PERIOD
PAID-UP ADDITIONS INSURANCE RIDER	$8.34	FOR LIFE

------ PAID-UP ADDITIONS TABLE OF VALUES ------

POLICY YEAR*	FACE AMOUNT OF PAID-UP ADDITIONS (BEGINNING OF YEAR)	CASH AND LOAN VALUE (END OF YEAR)	POLICY YEAR*	FACE AMOUNT OF PAID-UP ADDITIONS (BEGINNING OF YEAR)	CASH AND LOAN VALUE (END OF YEAR)
1	$ 393	$ 96	35	$ 8,511	$ 5,486
2	773	195	36	8,655	5,698
3	1,141	297	37	8,795	5,911
4	1,496	402	38	8,933	6,126
5	1,841	512	39	9,068	6,341
6	2,174	624	40	9,201	6,556
7	2,496	740	41	9,330	6,771
8	2,808	860	42	9,458	6,983
9	3,110	984	43	9,583	7,193
10	3,403	1,111	44	9,707	7,400
11	3,687	1,242	45	9,828	7,606
12	3,962	1,377	46	9,948	7,811
13	4,228	1,515	47	10,066	8,014
14	4,486	1,658	48	10,182	8,217
15	4,737	1,804	49	10,297	8,418
16	4,980	1,955	50	10,410	8,617
17	5,216	2,109	51	10,522	8,811
18	5,444	2,268	52	10,632	9,002
19	5,667	2,430	53	10,741	9,188
20	5,883	2,597	54	10,850	9,370
21	6,092	2,767	55	10,957	9,549
22	6,296	2,940	56	11,063	9,727
23	6,494	3,118	57	11,168	9,904
24	6,687	3,298	58	11,273	10,083
25	6,875	3,482	59	11,376	10,266
26	7,057	3,670	60	11,479	10,455
27	7,235	3,861	61	11,580	10,656
28	7,409	4,056	62	11,681	10,869
29	7,578	4,253	63	11,781	11,097
30	7,743	4,453	64	11,879	11,339
31	7,904	4,656	65	11,976	11,590
32	8,061	4,861	66	12,071	11,838
33	8,214	5,067	67	12,166	12,166
34	8,364	5,276			

* FOR PURPOSES OF THIS TABLE ONLY WE MEASURE POLICY YEARS FROM THE POLICY INFORMATION EFFECTIVE DATE SHOWN ABOVE.

THESE VALUES FOR THE PAID-UP ADDITIONS ASSUME THAT ALL PREMIUMS FOR THEM ARE PAID IN ACCORDANCE WITH THE ABOVE PREMIUM TABLE. THEY DO NOT REFLECT DIVIDEND CREDITS, WITHDRAWAL OF THE CASH VALUE OF PAID-UP ADDITIONS, OR LOANS.

-------- ENDORSEMENTS --------

AMENDMENT TO 'SUICIDE EXCLUSION': THE 'SUICIDE EXCLUSION' IS AMENDED BY DELETING THE PHRASE 'WHILE SANE OR INSANE.'

S.20-16

NSC

POLICY SUMMARY

POLICY NO. [redacted]6 693 | ORIG. OFFICE HDE 03313 | DATE 88/12/07 | COLL. OFFICE RAE

INSURED/ANNUITANT NAME	BIRTH DATE	ISS AGE	BIRTH STATE	SEX	RES STATE	MARITAL STATUS	SS OR TAX NO.	CLASS RATING
MR IOANNIS TRIANTAFILLOU	55/[redacted]	33	99	M	NY		[redacted]	N

PREM MODE	BIL TYPE	DIV. ELECT	PT DATE	IRR DATE	SERIES	IST OPAI DATE	WP RATE	AC RATE	SPB RATE
MONTHLY	REG	ADN			129		STD		

PLAN/OPTIONS	AMOUNT	BASIC PREMIUM	PT PREMIUM	IRR PREMIUM	FLAT EX PREMIUM	TYPE EX
WL50	500000	502.00*				
WP		35.00*				
PUA-MODAL	393	8.34*				
TOTALS		545.34				

OPTIONAL MODES

QTRLY	1,635.02*
SEMIAN	3,236.04*
ANNUAL	6,290.08*

BENEFICIARY	OWNER	MAILING ADDRESS
AS STATED IN APPLICATION	MR IOANNIS TRIANTAFILLOU	RT 303 BLAUVELT NEW YORK NY 10913

APP DATE	MED DATE	REG DATE	ISS/DCL DATE	STATE ACCT NO	VOL AMOUNT	REPORTABLE	COMM PREPD
88/11/08	88/11/17	88/11/17	88/12/07		500393	YES	YES

AGENTS NAME	NUMBER	CONT	%INT	PREPD ELCT	PROD CRED	INIT COMM	TYPE	DIST MANAGER	AM
LIMA	JJ 049376	14	50	YES-F	1728.10	1728.10	OSA	LIMA	60 050
SARETSKY	MS 090325	14	50	YES-F	1728.10	1728.10	COA	ELBARKLIMA	61 050

DELIVERY INSTRUCTIONS AND REQUIREMENTS	DELIVERY PER ENDS	CASH COLL	INIT PREMIUM	PUR. CR	AMOUNT TO
	89/02/15 C	545.33	545.34	COLL	.01

THE CONTRACT STATE IS NY. THE POLICY LOAN INTEREST DUE IN ADVANCE PERCENTAGE IS 7.4%.

NLIC-28 (4/88)

TRANSMITTAL/RATING SHEET

☐ REG ☐ ESP ☐ VLI ☐ Unpaid Change
☐ ANN ☐ DI ☐ H.Care ☐ LA

☑ REFERRED A/C ☐ APPROVED
☐ Pt. 1 _____
☐ Exam _____
☐ Age/Amount _____
☐ Other _____

EXAMINER'S NAME

REQUIREMENTS INITIATED (TYPE AND SOURCE) | DATE INITIATED

FIRST NAME: Ioannis MIDDLE: LAST: Triantafillou

ALPHA ASU & APP #/POLICY #: [redacted] 3313

SPECIAL INSTRUCTIONS / ATTACHMENTS:

☐ TERM CONV
☐ DROP-IN
☐ RESCUE PROGRAM
☐ WOLPER/ROSS

INSURANCE STATEMENT
500,000
NEW
PREV
TOT
ADDL
TOT
OTHER COS.
TOTAL ALL COS

	PROPOSED INSURED ☐ SMOKER ☐ NON-SMOKER				PROPOSED ADDITIONAL INSURED			75th DAY: CHILD(REN)		
	BUILD % +5 AGE 33M				BUILD % AGE			BUILD % AGE		
		DEBIT	CODE	ADB	DPW		DEBIT	CODE		DEBIT	CODE
	BUILD GIRTH F.H.	100				BUILD GIRTH F.H.			BUILD F.H.		
	6m		BHOR M.V.L.								
	2										
	TOTAL RATING										

CODES PROPOSED INSURED:

☐ PROPOSED ADDITIONAL INSURED:

FINAL RATE N ADB 0 DPW 1

☐ RTIP/LTIP 2 _____ ☐ SPB _____ ☐ CTI

☐ SEND AUD #

✓ PUA
PUA modal: 8.33
check prem @ issue

DELIVERY INSTRUCTIONS

☐ LIMIT DELIVERY TO: _____
☐ CLASSIFIED a/c _____

RIDERS, CLAUSES: ☐ ACCIDENT RISK

☐ POL. REV

REIN	CEDING CO	QUAL	OWNER	ASSOC-KEOGH UNIT #	ARMED SERV. PEN. TRUST SA #

BENEFICIARY INFORMATION

RELATIONSHIP	SEX 1	SEX 2	SETT	CONT	NAME

☐ ESS ☐ ESM ☐ ESP ☐ ESN
☐ 8 ☐ Group Conversion

BENEFICIARY

OWNER'S NAME

UNDERWRITER'S SIGNATURE J. Garvey DATE 12/7

PHOTO 180311

TRANSACTION	ISSUE	PHI/____	SUB	RES	ISS-PEN	DLR	RFN			
DATE	12-7									
REVIEWER	CM									

DATE	MESSAGE	REQUIREMENT REQUESTED	REQUIREMENT ATTACHED
12 5	Brief attached & updated 5m		
12 5	Attach app for PVA into 5m		
12-6	App attached PW		
12/6	Ltr MVR std DE Rec'd @ (2)		
12-7	total liability w/ PVA	500,000	
12/7	See TL		

DATE	MESSAGE	REQUIREMENT REQUESTED	REQUIREMENT ATTACHED

X 009 24 MIB

88/12/01 0913 05 REFER RAE HDE 03313 [redacted]6 693 IT

MR IOANNIS TRIANTAFILLOU 55[redacted] 33 99 NY M [redacted]

WL50 129 500,000 MONTHLY REGULAR

WP

ADDITIONS

REG DATE 88/11/17 REG PREM 537.00

545.33
.34

AS STATED IN APPLICATION CSH W APP 545.33 CASH
RES CITY 000

SINGLE SUM NC

NY 88/11/08 MEDICAL 88/11/17

ORIGINAL

RT 303 BLAUVELT

N 1

NEW YORK NY 10913

POLICY REVIEWS

BUREAU CASE PREPAYMT OVRD MARKET

ENDORSEMENTS

FORMS NY
126-51
126-51-4
126-51-6
126-51-8
R86-114
R85-201NY
R79-77

PAGE THREE ENDORSEMENTS

S.20-16

500,000.00 050 L 049376 5 50 S 090325 5

N

Signature(s) also required below.

ACKNOWLEDGEMENT AND AUTHORIZATIONS

UNDERWRITING PROCEDURES. I have received a statement of the underwriting procedures of The Equitable Life Assurance Society of the United States (Equitable), which describes how and why Equitable obtains information on my insurability, to whom such information may be reported and how I may obtain it. The statement also contains the notice required by the Fair Credit Reporting Act.

AUTHORIZATIONS.

To Obtain Medical Information. I authorize any physician, hospital, other medical practitioner or facility, insurance company, and the Medical Information Bureau to release to Equitable and its legal representative any and all information they may have about any diagnosis, treatment and prognosis regarding my physical or mental condition.

To Obtain Non-Medical Information. I authorize any employer, business associate, government unit, financial institution, Consumer Reporting Agency, and the Medical Information Bureau to release to Equitable and its legal representative any information they may have about my occupation, avocations, finances, driving record, character and general reputation.

I authorize Equitable to obtain investigative consumer reports, as appropriate.

To Use and Disclose Information. I understand that the information that I authorize Equitable to obtain will be used by Equitable to help determine my insurability or my eligibility for benefits under an existing policy.

I authorize Equitable to release information about my insurability to its reinsurers, my Equitable Agent, and to the Medical Information Bureau, all as described in the statement of Equitable's underwriting procedures, or to other persons or businesses performing business or legal services in connection with my application or claim of eligibility for benefits, or as may be otherwise lawfully required or as I may further authorize.

I understand that I have the right to learn the contents of any report of information (through my physician, in the case of medical information).

COPY OF AUTHORIZATIONS. I have a right to ask for and receive a true copy of this Acknowledgement and Authorizations signed by me. I agree that a reproduced copy will be as valid as the original.

DURATION. I agree that these authorizations will be valid for 12 months from the date shown below.

Louis Tripaldelli

Date Nov. 8, 1988

Signature(s)

Application Part 1 For Life Insurance To
THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES

☑ REG. ☐ JUV. ☐ ESP ☐ OPAI

1. Proposed Insured

a. Print name to appear on policy.
IOANNIS (First) TRIANTAFILLOU (Middle Initial) (Last)

b. ☒ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Other Title

c. List all current occupations—Give Title(s) and Duties
CO-OWNER T.I.P.I. RESTAURANTS INC.
MANAGERIAL DUTIES AT RESTAURANT

d. Date of Birth [redacted] (Month Day) 19 55 (Year)

e. Age Nearest Birthday 33

f. Place of Birth: State of GREECE

g. Residence: State of NEW YORK

h. ☒ Male ☐ Female

2. Plan

WHOLE LIFE 50

Amount of Insurance $ 500,000

3. Optional Benefits

☐ Accidental Death Benefit* (Specify Amount): $
☒ Disability Premium Waiver*
☐ Automatic Premium Loan (Not for Term policies, or while premiums are paid monthly)
☐ Option to Purchase Add'l Ins. (Issue ages to 37 only): $

Term Riders: (Only one may be elected for Insured. None available if Proposed Insured is a Child (Issue Age 0-14)

Decreasing Term
☐ Family Income: ____ Years $ ____ Per Month
☐ Mortgage Prot.: ____ Years Initial Amt.: $

Renewable Term
☐ On Insured: $
☐ On Additional Insured (See page 2): $
☐ Children's Term (See page 2): $ ____ Units

*If Proposed Insured is a Child (Issue Age 0-14) see Limitations on p.2.
OPAI and Decreasing Term not available for ESP.

4. Beneficiary for Insurance on Proposed Insured. Include Full Name and Relationship to Proposed Insured.

STAVRIANI TRIANTAFILLOU, MOTHER AND CHRISTOFOROS TRIANTAFILLOU, BROTHER, EQUALLY.

Unless otherwise requested, the contingent beneficiary will be the surviving children of the Insured, in equal shares. If none survive, payment will be made to the Insured's estate.

The Beneficiary under any Term Insurance Rider on an Additional Insured or on a Child will be as stated in those riders, unless otherwise designated in Special Instructions.

5. Owner

Owner's Soc. Sec. or Tax No. [redacted]

The Owner is ☒ Proposed Insured
☐ Applicant for Child (See 10.c.)
☐ Other (Give Full Name):

If "Other", complete the following:
☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Other Title
Relationship to Insured
Specify a successor Owner if desired

If the Proposed Insured or the Applicant for a Child is not the Owner and if all persons designated die before the Insured, the Owner will be the estate of the last of such persons to die except where the Insured is a Child (see Note in 10.c.).

6. Mailing Address

☒ Business (Give Full Name) ☐ Residence

BLAUVELT CO ACH DINER
(No.) (Street) (Apt.)
RT 303 BLAUVELT
(City)
NEW YORK [redacted] 10913
(State) (Zip)

7. Premium Payment Plan

☐ Annual ☐ Semi-Annual ☐ Quarterly
☒ Monthly ☐ System-Matic (Attach S-M Form)
☐ Single
☐ Military Allotment: Branch
Register Date
☐ Salary Allotment: Register Date
Unit Name
Unit/Sub-Unit No. if established:
Divisible by ☐ 2 ☐ 4 Payroll No.
☐ Hold Premium $

8. Dividend Election

☐ Economatic Type Policies
☒ Additions* ☐ Premiums
☐ Accumulations ☐ Cash
☐ Plan 'AD' ☐ Plan 'B' — Term Dividend Provision**

*Not Available for Term policies
**Not Available for Term policies or ESP.

9. Special Instructions

a. ☐ Preliminary Term to: (Month Day Year)
b. ☐ Date to save insurance age:
c. Other:
BASIC POLICY COST $ 502.00 / MO.
D.P.W. 35.00 / MO
PUA RIDER 5.33 / MO.

OTHER INFORMATION—Has any Person Proposed for Insurance:

14.a. Ever had a driver's license suspended or revoked or, within the last three years, been convicted of two or more moving violations or driving under the influence of alcohol or drugs? (Give full details—including dates, types of violation, and reason for license suspension or revocation.) ☐ Yes ☒ No

b. Any plan to travel or reside outside the U.S.? (Give full details.) ☐ Yes ☒ No

c. Any other life insurance now in effect or application now pending? (State companies and amounts.) ☐ Yes ☒ No

d. Smoked cigarettes within the last 12 months? ☐ Yes ☒ No

15.a. In the last year flown other than as a passenger or plan to do so? ☐ Yes ☒ No
If yes: Total flying time at present_____ Hours;
Last 12 mos._____ Hours; Next 12 mos._____ Est. Hours.
(Complete Aviation Supplement for pilot instruction; competitive, test, stunt or military flying; or crop dusting.)

b. Engaged within the last year, or any plan to engage in motor racing on land or water, underwater diving, sky diving, ballooning, hang-gliding or parachuting? (If yes, complete Avocation Supplement.) ☐ Yes ☒ No

c. Ever had an application for life or health insurance declined, that required an extra premium or was otherwise modified? (Give full details.) ☐ Yes ☒ No

d. Replaced or changed any existing insurance or annuity (or any plan to do so) assuming the insurance applied for will be issued? (State companies, plans and amounts.) ☐ Yes ☒ No

Answer Questions 16, 17 and 18 only if Non-Medical.

16. Proposed Insured: Height 5 Ft. 11 In. Weight 174 lbs.
Additional Insured: Height____ Ft.____ In. Weight____ lbs.

Has any Person Proposed for Insurance:

17.a. Ever been treated for or had any indication of heart trouble, stroke, high blood pressure, chest pain, diabetes, tumor or cancer? (Give full details.) ☐ Yes ☒ No

b. In the last 5 years, consulted a physician, or been examined or treated at a hospital or other medical facility? (Include medical check-ups in the last 2 years. Do not include colds, minor virus infections, minor injuries, or normal pregnancy.) (Give full details.) ☐ Yes ☒ No

18.a. In the last 10 years used barbiturates, amphetamines, hallucinatory drugs or narcotics? (Give full details.) ☐ Yes ☒ No

b. In the last 10 years received counseling or treatment for the use of alcohol or drugs? (Give full details.) ☐ Yes ☒ No

19. DETAILS. For each yes answer give Question number, name of person(s) affected and full details. *For 17 and 18 also include conditions, dates, durations, treatment and results, and names and addresses of physicians and medical facilities.*

No.	Name of Person Affected	Details

20. Complete if First Premium is Paid or a Payroll Deduction Authorization is Signed Before the Policy is Delivered:
Have the undersigned read and do they agree to the conditions of The Equitable's Temporary Insurance Agreement, including (i) the requirement that all of the conditions in that Agreement must be met before any insurance takes effect, and (ii) the $250,000 insurance amount limitation? ☒ **Yes** ☐ **No** *(If "No," a premium may not be paid nor a payroll deduction authorization signed before the policy is delivered.)*

☒ **Amount Paid: $** 54.33 *(Draw checks to order of The Equitable.)* ☐ **Payroll deduction authorization signed.**

AGREEMENT. Each signer of this application agrees that:

(1) The statements and answers in all parts of this application are true and complete to the best of my knowledge and belief. The Equitable may rely on them in acting on this application.

(2) The Equitable's Temporary Insurance Agreement states the conditions that must be met before any insurance takes effect, if the full first premium for the policy applied for is paid, or a payroll deduction authorization is signed, before the policy is delivered.

(3) Except as stated in the Temporary Insurance Agreement, no insurance shall take effect on this application: (a) until a policy is delivered and the full first premium for it is paid, or a payroll deduction authorization is signed, while the Proposed Insured is living; (b) before any Register Date specified in this application; and (c) unless to the best of my knowledge and belief the statements and answers in all parts of this application continue to be true and complete, without material change, as of the time such premium is paid or a payroll deduction authorization is signed.

(4) No agent or medical examiner has authority to modify this Agreement or the Temporary Insurance Agreement, nor to waive any of The Equitable's rights or requirements. The Equitable shall not be bound by any information unless it is stated in application Part 1, 1A or 2.

Dated at Bloomfield, NJ. (City, State) on 11-8 1988

(X) Joanne Tramontano
Signature of Proposed Insured (Employee for ESP) or of Applicant if Proposed Insured is a Child, Issue Age 0-14.

Signature of Additional Insured if required.

Signature of Purchaser if not Proposed Insured or Applicant. (If corp. show firm's name and signature of authorized officer.)

Signature of Agent John J. Lewis

10. Complete if Proposed Insured is a Child (Issue Ages 0-14).

a. Will there be more life insurance in effect on the Child than on any older child in the family? ☐ Yes ☐ No
If yes, explain: _____

b. **Applicant-Complete if other than the Child.**
i. _____ (First Name / Middle Initial / Last Name)
ii. ☐Mr. ☐Miss ☐Mrs. ☐Ms. ☐Other Title_____
iii. Date of Birth_____ (Month / Day) 19___ (Year)
iv. ☐ Male ☐ Female
v. Relationship to Child:_____
vi. Total Life Insurance now in effect: $ _____

c. **Owner.** If the Applicant is to be the Owner, after the Applicant's death the Child will be the Owner unless otherwise designated in Special Instructions (in any such designation include Owner's **Full Name, Relationship** to Child, and Social Security or Tax Number).
NOTE: *Consider designating an adult secondary Owner to reduce the chance of a minor Child becoming the Owner. If all persons designated die before the Child, the Owner will be the Child.*

d. **Optional Benefit On Applicant.**
☐ Supplemental Protective Benefit. Give Applicant's:
i. Age Nearest Birthday _____ ii. Place of Birth _____ (State)
iii. Height_____Ft.____In. Weight_____lbs.
iv. Occupations-Give Title(s) and Duties:_____
Also answer questions on page 3 as to Applicant.

e. ***Limitations On Child's ADB and DPW Benefits.***
If the Accidental Death Benefit is applied for on the Child, the benefit is payable only if the Child dies after the Child's first birthday.
If the Disability Premium Waiver Benefit is applied for on the Child, the benefit is effective only if the Child becomes totally disabled on or after the Child's 5th birthday.

11. Complete for Children's Term Rider.

☐ For Fixed Amount under ESP: Give names of Children below.
☐ For Any Other Amount or Plan: Give Names of Children below and answer the Questions on page 3 as to each Child.

CHILDREN PROPOSED FOR INSURANCE:
NOTE: *To be eligible, children (including stepchildren and legally adopted children) must not yet have reached their 18th birthday. Coverage does not begin until a child is 15 days old.*

First Name	Middle Initial	Last Name	Sex	Date of Birth Mo.	Day	Yr.

12. Complete for Renewable Term Rider on Additional Insured.

Complete below and answer the Questions on page 3 as to the Additional Insured.
☐ For ESP, the Additional Insured is to be the Spouse (subject to the Spouse amount limit).

PROPOSED ADDITIONAL INSURED
a. Print name as it is to appear on the Policy.
_____ (First / Middle Initial / Last)
b. List all current occupations—Give Title(s) and Duties.
_____
_____
_____

c. *Date of Birth:* Mo._____ Day_____ Yr. 19____
d. Age Nearest Birthday _____
e. Place of Birth: State of_____
f. Residence: State of _____
g. ☐ Male ☐ Female
h. Owner's Relationship to Additional Insured: _____

13. Complete if Using Existing Option to Purchase Insurance.

a. If Option is under Individual Policy:
i. Policy No._____ ii. Option Date_____
iii. Option Amount: $_____
iv. ☐ Regular Option or
☐ Option on Birth or Adoption of Child
Child's Name _____
Date of Birth or Adoption_____
v. If applying for Disability Premium Waiver, is Proposed Insured now totally disabled as defined in the Disability Premium Waiver provision of the above policy? ☐ Yes ☐ No

b. If Option is under Group Policy:
i. Policy No._____ ii. Option Date_____
iii. Employer's Name_____
iv. Maximum Amt. Available Under Option: $_____

This application is made under a provision in the policy indicated above permitting the purchase of individual life insurance (the "Option Provision").

If this application is made within the time allowed and in accordance with the other terms in the Option Provision, including timely payment of the full first premium for the option insurance, then the option insurance shall take effect upon the terms of the policy The Equitable would issue. Otherwise, the option insurance shall not take effect.

Answer the Questions on page 3 *only if evidence of insurability is required* in connection with an optional benefit or any excess of the insurance amount applied for over the insurance amount permitted by the Option Provision (the option insurance).

AGENT'S REPORT

(Complete 1-11 if Regular business. Complete 7-14 if ESP. Print in black ink.)

Pol. No. | Batch No. | Inq. No.

1. Purchaser:
a. If the Purchaser is other than the Insured/Applicant/a Trust, give the Purchaser's Annual Income $ _____
b. If the Purchaser is a Corporation or Partnership, also state names of officers/partners and amounts of insurance on their lives owned by the Purchaser.

2. a. How long have you known the Insured? 2 YEARS
b. Your relationship to the Insured, if any. NONE
c. If the Insured is a Child (Issue Ages 0-14) when did you last see the child? _____

3. Marketing Information.
a. Purpose - Check One:
Business Insurance
☐ 1. Split Dollar
☒ 2. Purchase Agreement
☐ 3. Section 303
☐ 4. Keyperson Indemnification
☐ 5. Deferred Compensation/ Income Continuation
☐ 6. Estate Planning
Personal Insurance
☐ 7. Family Income
☐ 8. Mortgage
☐ 9. Retirement
☐ 10. Education Funds
☐ 11. Emergency
☐ 12. Other _____
b. Source - Check One:
☒ 1. Client (Incl. Family)
☐ 2. Orphan
☐ 3. Cold Canvass
☐ 4. Direct Mail/Adv.
☐ 5. Referred Lead
☐ 6. Friend/Neighbor
☐ 7. Other _____

4. Proposed Insured's (If Insured is a Child, Issue Age 0-14, complete as to Applicant):
a. Name IOANNIS TRIANTAFILLOU b. Date of Birth (Month) 6 (Day) 7 (Year) 55
c. Annual Earned Income $ 30,000 d. Previous Married or Maiden Name _____
e. Residence: *If rural residence, state road and distance to nearest town (P.O. Box Unacceptable)*

	Number and Street	City and State	Zip	County	Years at Residence
Current	6 KIRCHNER DR.	WEST NYACK, N.Y.	10914	ROCKLAND	4 YRS
Previous*					

*If less than two years at current address

f. Business Address:

Employer	Number and Street	City and State	Zip	County	Years With
BLAUVELT COACH DINER	RT. 303	BLAUVELT, N.Y.		ROCKLAND	5 YEARS

g. Bank Name, Branch Location & Acct. No. **(Only on applications over $100,000)**
MARINE MIDLAND - BLAUVELT N.Y. ACCT # [redacted] 3059
Submit form 153-300 for applications over $250,000.

5. If Insured is a Child (Issue Age 0-14): Child's Name: _____ Residence Address: _____ Date of Birth: (Mo.) (Day) (Yr.) 19

6. Allotment: Unit Name _____ Allotor's ID No. _____
Allotor's Name if not the Insured _____

7. Production Credits

(Print) Agent's Name(s) (Service Agent)	Initial of Last Name	Number	% Int.	ASU to Check 4	ASU to Check 5
JOHN J. LIMA	L	0 4 9 3 7 6	50		X
MICHAEL SARETSKY	S	0 9 0 3 2 5	50		X

8. REMARKS:

9. Telephone No. where we can reach Proposed Insured (Applicant if Proposed Insured is a Child, or Employee if ESP):
☒ Business (914) 359-5152
☐ Home (___) _____

10. *Will any existing insurance or annuity be replaced or changed (or has it been) assuming the insurance applied for will be issued?* ☐ *Yes* ☒ *No*

11. Except for any medical Part 1A or Part 2, I certify that I have asked and recorded completely and accurately the answers to all questions on the application and I know of nothing affecting the risk that has not been recorded herein.
I ☒ *have* / ☐ *have not* *witnessed the signature(s) required on Part 1.*
Signature John J. Lima Date 11-6-88
Agency & Code No. 050 District 61

12. ESP-Employer/Unit Name _____
Employee's Name _____ ID No. _____
13. If the Employee is not the Proposed Insured:
Proposed Insured's Name _____ and relationship to Employee _____
14. Employee's Annual Earned Income $ _____

APP. NO. ASU HDE 03313 | ASU Recd. 11/15/88 | Date to RSC 11/30/88 | Med. Date 11/17/88 | RSC Recd. [illegible]

OFF. USE

Unit/Sub-1. Unit No. _____ Unit Due Day ___ | Divisible by ☐2 ☐4 ☐Hold Premium $ _____ Coll. RSC _____

2. ☐ Cash $ _____ ☐ Signed, no settlement ☐ Unsigned
☐ Note Dated _____ ☐ Dividend ☐ 237
☐ Payroll Deduction Card
3. ○ Campaign 4. MIL. CODE _____
5. ☐ Preliminary Term or ☐ Irregular To _____
6. ○ Annual ○ Semi ○ Quarterly ○ Monthly ○ Single ○ S-M ○ Mil
10. Insured's Occupation _____
11. *Preliminary Action* ☐ *Approved* ☐ *Referred* By _____

7. Plan _____ ☐ AC $ _____ ☐ WP ☐ SPB ☐ APL
Face Amount _____ ☐ Children's Term _____ units
RTIP-Ins. _____ ○ RTIP-Addl. Ins. $ _____
MORT-Yrs. _____ $ _____ ☐ OPAI
FI—Yrs. _____
_____ $/mo. $ _____ 8. Volume Amount $ _____
Initial Liability $ _____ 9. ☐ Inspection Initiated

SIP

LIFE-301L SUB _____ EDIT _____ ISS _____ 4

DATAFLO SYSTEMS *an Equifax Company*
DRIVER RECORD INFORMATION A Dataflo Systems Service

500,000

Obtained by DATAFLO SYSTEMS, on customer's behalf, from the state of motor vehicle records. Identification of driver based on information submitted.

[redacted]

TRIANTAFILOU,I
KIRSCHNER DR
NYACK NY 10994
COUNTY: ROCK

71569/APP # HDE 03313

[redacted]	11/30/88	335 AL 000142	000099NEC
	80		
[redacted]55	M		

DRIVER LICENSE INFORMATION

ISSUED	EXPIRES	STATUS
	06/07/92	

MISCELLANEOUS AND STATE SPECIFIC INFORMATION

DRIVING RECORD

DATE	DESCRIPTION
CONV 05/03/86	04/11/86 PASSED RED LIGHT COUNTY: QUEE
	COURT: 50 BATCH ID#: 6041100871 FINE: 50

2

FILED
SEP -6 A 11:52

Copy
11-7-87
approved Ben

EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES
STANDARD LEDGER STATEMENT
Whole Life 50

PREPARED FOR : JOHN TRINTAFILLOU
MALE NONSMOKER AGE 33
DIVIDENDS APPLIED TO PAID UP ADDITIONS FOR 32 YEARS
THEN APPLIED TO REDUCE PREMIUM

FACE AMOUNT: $ 500,000
ANNUAL PREMIUM: $ 6,290.00
INCLUDES PUA RIDER PAYMENT

POLICY YEAR	AGE	EFFECTIVE PREMIUM	GUAR CASH VALUE	CASH VAL DIVIDEND ADDITIONS	PAID UP ADD RIDER CASH VAL	FACE OF DIVIDEND ADDITIONS	PAID UP ADD RIDER FACE AMT	TOTAL CASH VALUE	TOTAL DEATH BENEFIT
1	33	6,290	0	0	99	0	408	99	500,408
2	34	6,290	0	0	201	0	802	460	501,060
3	35	6,290	11,500	270	307	1,800	1,183	12,473	503,377
4	36	6,290	17,500	697	417	4,426	1,552	19,412	506,776
5	37	6,290	23,500	1,565	530	9,495	1,909	26,922	512,730
6	38	6,290	29,500	3,026	647	17,540	2,254	35,064	521,684
7	39	6,290	36,000	5,144	767	28,497	2,588	44,390	533,563
8	40	6,290	43,000	7,972	891	42,227	2,912	54,830	548,105
9	41	6,290	49,500	11,436	1,019	57,936	3,225	65,499	564,703
10	42	6,290	56,500	15,656	1,151	75,885	3,529	77,400	583,506
11	43	0	63,500	14,165	1,188	65,717	3,529	83,974	574,366
12	44	0	70,500	13,676	1,226	60,756	3,529	90,934	569,816
13	45	0	77,500	13,590	1,264	57,830	3,529	98,330	567,334
14	46	0	85,000	13,958	1,304	56,916	3,529	107,550	567,733
15	47	0	92,500	14,820	1,344	57,928	3,529	116,994	569,787
16	48	0	100,000	16,241	1,385	60,871	3,529	127,103	573,877
17	49	0	108,000	18,273	1,427	65,695	3,529	138,465	579,988
18	50	0	116,000	20,996	1,469	72,435	3,529	150,628	588,125
19	51	0	124,000	24,467	1,513	81,031	3,529	163,679	598,258
20	52	0	132,500	28,773	1,557	91,524	3,529	178,209	610,430
21	53	0	141,000	33,984	1,602	103,891	3,529	193,789	624,622
22	54	0	149,000	40,925	1,648	120,315	3,529	209,998	642,268
23	55	0	158,000	49,049	1,694	138,762	3,529	228,470	662,018
24	56	0	166,500	58,435	1,740	159,180	3,529	247,732	683,766
25	57	0	175,500	69,169	1,787	181,537	3,529	268,879	707,488

Initial Premium

Benefits Included	Annual	Semi-Annual	Quarterly	Regular Monthly	Special Monthly
Base Policy	5,780.00	2,976.00	1,505.00	502.00	501.00
* PUA Rider	100.00	50.00	25.00	8.33	8.33
DPW	410.00	210.00	105.00	35.00	35.00

This illustration is not valid without accompanying SUPPLEMENTAL FOOTNOTE PAGE.
Dividends,or any figures depending upon them, are illustrations based on the Equitable's 1988 dividend scale applicable to currently issued policies, which reflect interest earnings on policies issued since January 1, 1987. The dividends are neither guaranteed nor estimates. Future dividends will depend on experience.

Policy value columns which are not specifically referred to as guaranteed include non-guaranteed elements(i.e., dividends) in whole or in part.

EQUITABLE LIFE — APPLICATION DATA REVIEW (CONTINUED) — PAGE 4 ** DUPLICATE **

APP.# HDE03313 ADR DATE 11/30/1988
PROPOSED INSURED TRIANTAFILLOU, IOANNIS

OFFICE USE BOX

1. Unit/Sub-Unit No. **NI** Due Date **NI** Hold Prem. **NI**
2. Settlement Cash | $545.33 Coll LIC **NI**
3. Campaign N
4. Military Status **NI**
5. Preliminary Term To **NI**
6. Premium Payment Plan
   MONTHLY
7. Plan WL50 Face Amount $500,000
   Features DPW PUA
   Initial Liability $500,004
8. System Calculated Volume $500,000
   Manually Calculated Volume **NI**
   Is Supplement to Application Part 1 attached ? Y
11. Preliminary Action - Referred A/C
    MEDICAL
    BHORL
    TOTAL LIABILITY AMOUNT REQUIREMENTS

ASU Received Date 11/15/1988

REQUIREMENTS DATA

REQUIREMENT	REQUEST DATE	WAIVED OR RECEIVED	WAIVED/REC'D DATE
MOTOR VEHICLE REPORT	11/15/1988	**NI**	**NI**
BLOOD SPECIMEN HOME OFFICE REF LAB	11/15/1988	**NI**	**NI**
LARGE AMOUNT SUPPLEMENT	11/15/1988	RECEIVED	11/15/1988

SUPPLEMENT TO APPLICATION PART 1

FOR: ☒ **The Equitable Life Assurance Society of the United States**
☐ **The Equitable Variable Life Insurance Company**

Note: *This Supplement must be completed by the Person Proposed for Insurance in all cases. No application for life insurance will be accepted without this Supplement.*

Please complete the following:

1. Has any Person Proposed for Insurance ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? Give full details below. ☐ Yes ☒ No
2. Has any Person Proposed for Insurance ever been treated by a member of the medical profession for AIDS or ARC? Give full details below. ☐ Yes ☒ No

Details. _____

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be made a part of the application for insurance. The Insurer may rely on them in acting on this application.

Dated at Bloomvelt (City), N.Y. (State) on 11-8 19 88

Signature of Proposed Insured, or Applicant if Proposed Insured is a Child

Signature of Additional Insured

John J. Lima
Signature of Agent

180-311A

Application Part 2 (180-M205M)

☒ **To The Equitable Life Assurance Society of the United States**
☐ **Or To Equitable Variable Life Insurance Company**

Reason for submission of this form: ☒ New Policy ☐ Policy Change ☐ Reinstatement

1. a. Proposed Insured (Please Print) First Name: IOANNIS Middle Initial: Last Name: TRIANTAFILLOU b. Height: 5 ft. 9 in. c. Weight: 180 lbs. d. Birth Date: Mo. [redacted] Day [redacted] Yr. 55 e. ☒ Male ☐ Female

2. a. Name and address of personal physician (or medical facility used instead): (*If none, so state*) NONE
   b. Date and reason last consulted if within the last 5 years:
   c. What treatment was given or recommended? (*If none, so state*)

3. Has Proposed Insured ever been treated for or ever had any known indication of: (*Circle items that apply*)

	Yes	No
a. Disease or disorder of eyes, ears, nose or throat?	☐	☑
b. Dizziness, fainting, convulsions; paralysis or stroke; psychiatric, psychological or emotional problem or disturbance; mental or nervous disease or disorder?	☐	☑
c. Shortness of breath; blood spitting; bronchitis, asthma, emphysema, tuberculosis or other chronic respiratory disease or disorder?	☐	☑
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease or disorder of the heart or blood vessels?	☐	☑
e. Ulcer, hernia, colitis, intestinal bleeding; jaundice, hemorrhoids, or other disease or disorder of the stomach, intestines, liver or gallbladder?	☐	☑
f. Sugar, albumin, blood or pus in urine; stone or other disease or disorder of kidney or bladder?	☐	☑
g. Diabetes; cyst, tumor, or cancer; thyroid or glandular disorder; skin disease or disorder?	☐	☑
h. Neuritis, arthritis, gout, or disease or disorder of the muscles or bones, including the back, or joints?	☐	☑
i. Deformity, lameness or amputation?	☐	☑
j. Allergies; anemia; other blood or lymph disease or disorder?	☐	☑
k. Disorder of prostate, reproductive organs, breasts, menstruation or pregnancy?	☐	☑
4. Is Proposed Insured now under observation or taking treatment?	☐	☑
5. Has Proposed Insured: a. Ever used barbiturates, amphetamines, hallucinatory drugs, heroin, opiates or other narcotics, except as prescribed by a physician?	☐	☑
b. Ever received counseling or treatment regarding the use of alcohol or drugs?	☐	☑
6. Other than as stated in answers to Questions 2-5, has Proposed Insured within the last 5 years: a. Consulted or been examined or treated by any physician or practitioner?	☐	☑
b. Had any illness, injury, or surgery?	☐	☑
c. Been a patient in or been examined or treated at a hospital, clinic, sanatorium, or other medical facility?	☐	☑
d. Had electrocardiogram, X-ray, or other diagnostic test?	☐	☑
e. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed?	☐	☑
7. Has Proposed Insured's weight changed by more than 10 pounds in the last 6 months?	☐	☑
8. Have any of the Proposed Insured's parents, brothers or sisters ever had cancer, diabetes, high blood pressure or heart disease before age 60? If yes, specify person and condition.	☐	☑

9. Family History:

	Age if Living	Cause of Death	Age at Death
Father	[redacted]	old age	[redacted]
Mother	70		
Brothers (1) and Sisters	44	good health	

DETAILS FOR YES ANSWERS. Include:
i. Question Number.
ii. Diagnosis and Treatment.
iii. Results.
iv. Dates and Duration.
v. Names and Addresses of all attending physicians and medical facilities.

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application for insurance or request for policy change or reinstatement, as the case may be. The Insurer may rely on them in acting on the application or making the policy change or reinstatement.

Dated at BLAUVELT (city) NY (state) on NOV. 17 1988 Ioannis Triantafillou
Signature of Proposed Insured

Witness: [signature]

Medical Examiner's Report
To The Equitable Life Assurance Society of the United States
Or To Equitable Variable Life Insurance Company

10. a. Height (Without shoes)	10. b. Weight (Clothed)	10. c. Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
5 ft. 9 in.	180 lbs.	44 in.	43 in.	36 in.

10. d. Did you weigh? ☑ Yes ☐ No 10. e. Did you measure? ☑ Yes ☐ No

Details of "Yes" answers (Identify item.)

NOV 2 8 RECD

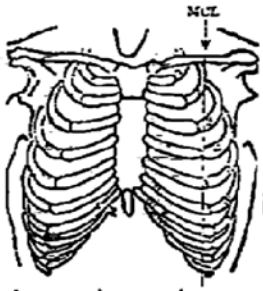
11. Blood Pressure—Record 1st Reading. If reading exceeds 140 systolic and/or 90 diastolic, obtain and record 2nd and 3rd Readings at 5 min. intervals.

	1st Reading	2nd Reading	3rd Reading
Systolic	105		
Diastolic — 5th phase	70		

12. Heart: Is there any:
Enlargement ☐ Yes ☑ No Dyspnea ☐ Yes ☑ No
Murmur(s) ☐ Yes ☑ No Edema ☐ Yes ☑ No
(Describe below — if more than one, describe separately)

	1st Murmur	2nd Murmur
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Specify Location:		
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate:
Apex by X
Murmur area by ○
Point of greatest intensity by O
Transmission by ▷



For comments and your impression:

13. Pulse:

	At Rest	After Exercise	3 Minutes Later
Rate	80	93	85
Irregularities per min. (indicate 0, if none)	0	0	0

14. Is there on examination any abnormality of the following:
(Circle applicable items and give details.)

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☑
(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	☐	☑
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☑
(d) Respiratory system?	☐	☑
(e) Abdomen (include hernias and scars)?	☐	☑
(f) Genitourinary system (include prostate)?	☐	☑
(g) Endocrine system (include thyroid and breasts)?	☐	☑
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☑

15. Are you aware of additional medical history? ☐ ☑
(A confidential report may be sent to the Medical Department)

16. Urinalysis: Test used (Dip Stick, Clinitest, etc.) _____
Specific gravity: _____

	Yes	(Am't)	No
a. Is protein present?	☐	( )	☑
b. Is sugar present?	☐	( )	☑
c. Is blood present?	☐	( )	☑
d. Is a specimen being sent to the Laboratory?	☑		☑

Send Specimen (with completed identification slip) To Laboratory If:
(1) urine tested is abnormal, or
(2) any genitourinary disease is or has been present.

IMPORTANT: This report is the property of the Insurer and must be mailed immediately to the Agency Service Manager. It should not be given to any other person.

State in which you are licensed to practice medicine? NY Type of practice? ☑ General ☐ Specialty

I made the examination reported above on NOV. 17 19 82 at BLAUVELT COACH LINER, RT. 303 SOUTH, BLAUVELT, NY
Time of exam _____ ☑ A.M. ☐ P.M. date address
Are you related to the Applicant or Agent? ☐ Yes ☑ No (Signature) _____ M.D.
Name of Agent: OBI / JOHN LIMA Address: INDEPENDENT HEALTH REPORTS, INC.

Before Mailing, Please Review Entire Report To Make Certain That Every Question Is Properly Answered